RCVD 7/2/04 Prop 67 43 GW

Health and Safety Code, the Revenue and Taxation Code and the Welfare and Institutions Code



This initiative measure is submitted to the people in accordance with the provisions of Section 8 of Article II of the California Constitution.

This initiative measure amends, repeals, and adds sections to the ~~Elections Code and the Government Code~~; therefore, existing provisions proposed to be deleted are printed in ~~strikeout type~~ and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

**PROPOSED LAW**

SUBJECT TO COURT ORDERED CHANGES

SA2003RF0043

~~INITIATIVE MEASURE TO BE SUBMITTED TO VOTERS~~

SECTION 1. Findings and Declaration of Purposes

(a) Access to hospital trauma and emergency medical services in California is in critical condition. The ability of hospitals and physicians to meet the demand for trauma and emergency services, including necessary follow up hospital care to patients admitted through emergency rooms, is strained to the breaking point. The lack of adequate urgent care alternatives, particularly for those without insurance or the ability to pay for medical services, puts added stress on hospital emergency departments. Patients often wait for hours in overcrowded emergency rooms for treatment, and seriously injured patients are increasingly being diverted past the nearest hospitals.

(b) The "911" emergency telephone system serves as a life-line for countless Californians each year. Californians deserve a high quality system that ensures that each emergency call is answered immediately.



(c) Firefighters and paramedics are the first on the scene to provide medical care to accident or disaster victims. The medical care they provide can mean the difference between life and death. They must be appropriately trained and equipped to respond to medical emergencies.

(d) Emergency physicians and on-call physician specialists provide hundreds of millions of dollars of uncompensated medical care annually. As a consequence, fewer doctors are available to provide emergency medical services.

(e) The operation of emergency departments and the provision of emergency and related services costs hospitals many hundreds of millions of dollars annually. These losses have contributed to the closure of 26 hospitals between 1995 and 2003 with a corresponding reduction in emergency care. Other hospitals are threatened with closure or reductions in emergency care. The people intend, by adopting this Act, to allocate funds to all hospitals operating licensed emergency departments in the manner specified in order to support and augment hospital emergency services and to help prevent the further erosion of such services. Because all hospitals with emergency rooms have a legal obligation to provide emergency services, all hospitals operating emergency rooms should share state funds available under this Act based upon their relative emergency department volume, uncompensated care, provision of charity care, and provision of care to county indigent patients, as specified.

(f) Community clinics are an important part of the emergency medical system and the continuum of emergency care. Community clinics provide services that prevent emergent conditions from developing; reduce unnecessary emergency room use; and also provide follow-up care for patients discharged from the emergency room. This keeps patients from unnecessarily using or returning to the emergency room. However, community clinics are financially threatened by the growing number of uninsured patients they must treat.

(g) Emergency medical care is a vital public service, similar to fire and police services, and is the back-bone of the health care safety net for our communities. By providing high quality trauma and emergency care, lives will be saved and taxpayer costs for healthcare will be reduced.

(h) Currently the state funds the 911 emergency telephone system with a surcharge on telephone calls made within California. A small increase in the existing emergency telephone surcharge, no more than 50 cents per month for households, is appropriate to enhance the delivery of emergency medical care and to help offset the costs of uncompensated emergency medical care in California.

(i) The people of the state of California hereby enact the 911 Emergency and Trauma Care Act to create an ongoing fund to improve the 911 emergency telephone system; to improve the training and equipment of firefighters and paramedics; and to improve, and to preserve and expand access to, trauma and emergency medical care.

(j) The intent of this Act is to provide additional funding for emergency medical services for the health and welfare of our residents. Further, existing funding, although inadequate, must be protected and maintained so that the intent of this Act is realized.



SECTION 2. Supplemental Funding for Emergency and Trauma Services

SEC. 2.1. is added to

Section 41020.5 ~~of Article 1 of Chapter 2 of Part 20 of Division 2 of~~ the Revenue and Taxation Code ~~is added~~ to read:

§ 41020.5(a) The surcharge imposed pursuant to section 41020 shall be increased at a rate of ~~three~~ percent (3%) on amounts paid by every person in the state on intrastate telephone communication service of the charges made for such services. The increase in surcharge shall be paid by the service user and shall be billed and collected in the same manner as the surcharge imposed pursuant to section 41020.

(b) Notwithstanding subdivision (a), the surcharge shall not be imposed on residential service users of lifeline telephone services pursuant to Article 8 of Chapter 4 of the Public Utilities Code, commencing with section 871) Division 1 of Part 1

(c) Notwithstanding subdivision (a), no service provider shall bill a surcharge to, or collect a surcharge from, a residential service user that exceeds ~~fifty~~ cents ($.50) per month. For purposes of this section, the term "residential service user" does not include mobile telecommunication services.

Section 41135 ~~of Article 2 of Chapter 7 of Division 2~~ of the Revenue and Taxation Code is amended to read:

SEC. 2.2.

§ 41135. All amounts required to be paid to the state under this part shall be paid to the board in the form of remittances payable to the State Board of Equalization of the State of California. The board shall, on a quarterly basis, transmit the payments to the State Treasurer to be deposited in the State Treasury ~~to the credit of the State Emergency Telephone Number Account in the General Fund which is hereby created.~~ and credited to the 911 Emergency and Trauma Care Fund and the following accounts within that fund, which are hereby created:

(a) to the State Emergency Telephone Number Account, all of the amounts collected pursuant to section 41020.

(b) to the State Emergency Telephone Number Account, three-fourths of ~~one~~ percent (0.75%) of the amounts collected pursuant to section 41020.5.

(c) to the Emergency and Trauma First Responders Account, ~~three~~ and three-fourths percent (3.75%) of the amounts collected pursuant to section 41020.5;

(d) to the Community Clinics Urgent Care Account, ~~five~~ percent (5%) of the amounts collected pursuant to section 41020.5;

(e) to the Emergency and Trauma Physician Uninsured Account, ~~thirty~~ and one-half percent (30.5%) of the amounts collected pursuant to section 41020.5; and

(f) to the Emergency and Trauma Hospital Services Account, ~~sixty~~ percent (60%) of the amounts collected pursuant to section 41020.5.

(g) There is also hereby created in the fund the Emergency and Trauma Physician Unpaid Claims Account to receive funds pursuant to section 1797.99a of the Health and Safety Code and sections 16950(c) and 16950.2 of the Welfare and Institutions Code.

SECTION 3. Administration of the State Emergency Telephone Number Account.

SEC. 3.1. Section 41136.5 ~~of Article 2 of Chapter 7 of Part 20 of Division 2 of~~ the Revenue and Taxation Code ~~is added~~ to read:

§ 41136.5. Funds in the State Emergency Telephone Number Account credited pursuant to section 41135(b) shall be continuously appropriated to and administered by the Department of General Services solely for technological and service improvements to the basic emergency phone number system. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section. The Department of General Services shall establish criteria for disbursing funds to state or local agencies pursuant to this section.

SEC. 3.2. Section 41136.6 ~~of Article 2 of Chapter 7 of Part 20 of Division 2 of~~ the Revenue and Taxation Code ~~is added~~ to read:





SUBJECT TO COURT ORDERED CHANGES

41136.6.

subdivision (a) of

Funds in the State Emergency Telephone Number Account credited pursuant to section 41135(a) may not be used to satisfy any debt, obligation, lien, pledge, or any other encumbrance, except as provided in section 41136.

SECTION 4. Administration of Emergency and Trauma First-Responders Account.

SEC. 4.1. Section 1797.117 ~~of Chapter 3 of Division 2.5 of~~ the Health and Safety Code ~~is added~~ is added to read:

§1797.117. Funds in the state Emergency and Trauma First-Responders Account shall be continuously appropriated to and administered by the Office of the State Fire Marshal. The Office of the State Fire Marshal shall allocate those funds solely to the California Firefighter Joint Apprenticeship Training Program, for training and related equipment for firefighters and pre-hospital emergency medical workers. The California Firefighter Joint Apprenticeship Training Program shall deliver the training as required by subdivision (c) of section 8588.11 of the Government Code. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.



SECTION 5. Administration of Community Clinics Urgent Care Account

SEC. 5.1. Article 6 (commencing with section 1246) is added to Chapter 1 of Division 2 of the Health and Safety Code ~~(commencing with section 1246) is added~~ to read:

Article 6. Administration of Community Clinics Urgent Care Account

§1246(a) There is hereby established the Community Clinics Urgent Care Account in the 911 Emergency and Trauma Care Fund. Funds in the Community Clinics Urgent Care Account shall be continuously appropriated to and administered by the Office of Statewide Health Planning and Development solely for the purposes of this section. The office shall allocate the funds for eligible nonprofit clinic corporations providing vital urgent care services to the uninsured. The funds shall be allocated by the office pursuant to the provisions of subdivisions (b) and (c). Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(b) Annually, commencing August 1, 2005, the office shall allocate to each eligible nonprofit clinic corporation a percentage of the balance present in the Community Clinics Urgent Care Account as of July 1 of the year the allocations are made and subject to subdivision (d), based on the formula provided for in subdivision (c).

(c) Funds in the Community Clinics Urgent Care Account shall be allocated only to eligible nonprofit clinic corporations. Funds in the Community Clinics Urgent Care Account shall be allocated to eligible nonprofit clinic corporations on a percentage basis based on the total number of uninsured patient encounters.

(1) For purposes of this section, an "eligible nonprofit clinic corporation" shall meet the following requirements:

(A) The corporation shall consist of non-profit free and community clinics licensed pursuant to subdivision (a) of section 1204 or of clinics operated by a federally recognized Indian tribe or tribal organization and exempt from licensure pursuant to subdivision (c) of section 1206.

(B) The corporation must provide at least 1,000 uninsured patient encounters based on data submitted to the Office for the year the allocations are made.

(2) The total number of uninsured patient encounters shall be based on data submitted by each eligible non-profit clinic corporation to the Office pursuant to the reporting procedures established by the Office under Health & Safety Code ~~section 1216~~. Beginning August 1, 2005, and every year thereafter, the allocations shall be made by the Office based on data submitted by each eligible non-profit clinic corporation to the Office by February 15 of the year the allocations are made.

(3) For purposes of this section, except as otherwise provided in ~~subdivision~~ (4), an uninsured patient encounter shall be defined as an encounter for which the patient has no public or private third party coverage. An uninsured patient encounter shall also include encounters involving patients in programs operated by counties pursuant to Welfare and Institutions Code ~~sections 16900 et. seq. and 17000.~~

(4) Each uninsured patient encounter shall count as one encounter, except that the encounters involving patients in programs operated pursuant to Welfare and Institutions Code ~~sections 14132(aa)(1) et. seq. and 24000 et. seq.~~, and pursuant to Health and Safety Code ~~sections 124025 et. seq.~~ shall count as 0.15 encounter for purposes of determining the total number of uninsured patient encounters for each eligible non-profit clinic corporation.

(5) The Office shall compute each eligible non-profit clinic corporation's percentage of total uninsured patient encounters for all eligible non-profit clinic corporations and shall apply the percentages to the available funds in the Account to compute a preliminary allocation amount for each eligible non-profit clinic corporation. If the preliminary allocation for an eligible non-profit clinic corporation is equal to or less than twenty-five thousand dollars ($25,000), the allocation for that eligible non-profit corporation shall be twenty-five thousand dollars ($25,000).

(6) For the remaining eligible non-profit clinic corporations, the Office shall compute each remaining eligible non-profit clinic corporation's percentage of total uninsured patient encounters for the remaining eligible clinic corporations and shall apply the percentage to the remaining funds available to determine the allocation amount for each remaining eligible non-profit clinic corporation, subject to ~~subdivision~~ (7).

(7) No eligible non-profit clinic corporation shall receive an allocation in excess of 25 percent of the total ~~monies~~ distributed to all eligible non-profit clinic corporations in that year.

(d) The Office of Statewide Health Planning and Development shall be reimbursed from the Community Clinics Urgent Care Account for the Office's actual cost of administration. The

SEC. 6.1.

total amount available for reimbursement of the Office's administrative costs shall not exceed 1% of the monies credited to the Account during the fiscal year.

percent moneys

SECTION 6. Administration of Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts. (Commencing with Section 1797.98a)

~~Existing~~ Chapter 2.5 of Division 2.5 of the Health and Safety Code is repealed ~~in its entirety~~.

~~CHAPTER 2.5. THE MADDY EMERGENCY MEDICAL SERVICES FUND~~

~~§ 1797.98a. Establishment; purposes.~~

wrong LRP material. See attached.

~~(a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.~~

~~(b) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The money in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state. Costs of administering the fund shall be reimbursed by the fund, up to 10 percent of the amount of the fund. All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section. The fund shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county. Fifty-eight percent of the balance of the money in the fund after costs of administration shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized, 25 percent of the balance of the fund after costs of administration shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services, and 17 percent of the balance of the fund after costs of administration shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.~~

~~(c) The source of the money in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.~~

~~§ 1797.98b. Report to legislature; listing of reimbursements~~

~~(a) Each county establishing a fund, on January 1, 1989, and on each January 1 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall include, but not be limited to, all of the following:~~

wrong CMF. See attached.

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians, the dollar amount of the total allowable claims submitted, and the percentage at which such claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(b)(1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.



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§ 1797.98e. Submission of losses for reimbursement; payment after reimbursement; limitations; agency notice to physicians and surgeons

(a) Physicians and surgeons wishing to be reimbursed shall submit their losses incurred as a result of patients who do not make any payment for services and for whom no responsible third party makes any payment. No physicians and surgeons shall be reimbursed in an amount greater than 50 percent of those losses.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

wrong LAF. See attached.

~~(c) Reimbursement for losses incurred by any physician and surgeon shall be limited to services provided to a patient who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and where all of the following conditions have been met:~~

~~(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.~~

~~(2) The physician and surgeon has billed for payment of services.~~

~~(3) Either of the following:~~

~~(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.~~

~~(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.~~



~~(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of funds from the fund.~~

~~(d) A listing of patient names shall accompany a physician and surgeon's submission, and these names shall be given full confidentiality protections by the administering agency.~~

~~(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.~~

~~(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.~~

~~(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.~~

~~§ 1797.98e. Legislative intent; system of administration; administering officer; disbursements; records; inspection and examination of books; limitations of payments from fund; procedure for resolution of disputes~~

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S.4

Wrong LAF See attached.

~~(a) It is the intent of the Legislature that a simplified, cost efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment . When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer.~~

~~(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.~~

~~(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out the provisions of this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.~~





SUBJECT TO COURT ORDERED CHANGES

Wrong LAF, see attached.

~~(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.~~

~~(e) All payments from the fund pursuant to Section 1797.98e to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.~~

~~(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:~~

~~(1) A basic or comprehensive emergency department of a licensed general acute care hospital.~~

~~(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.~~

~~(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.~~

~~(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.~~

~~(g) Payments shall be made only for emergency services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days, however, payments may not be made for services provided beyond a 48-hour period of continuous service to the patient.~~

~~(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days, however, payments may not be made for services provided beyond a 48-hour period of continuous service to the patient.~~

~~(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).~~

~~(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall~~





SUBJECT TO COURT ORDERED CHANGES

provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

§ 1797.98f. Reimbursement of emergency physician or surgeon with gross billing arrangement with hospital

Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department, or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

§ 1797.98g. Emergency medical services funds; physician services account; effect of law

The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and

# HEALTH AND SAFETY CODE SECTION 1797.98a-1797.98g

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund, up to 10 percent of the amount of the fund.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionately based on

the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

(3) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(4) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon and hospital claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(6) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contracted to review claims payment methodologies.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to

patients by any physician and surgeon shall be limited to services provided to a patient who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment,

the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out the provisions of this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care

rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(g) Payments shall be made only for emergency services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days, however, payments may not be made for services provided beyond a 48-hour period of continuous service to the patient.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days, however, payments may not be made for services provided beyond a 48-hour period of continuous service to the patient.



(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

1797.98f. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department, or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

1797.98g. The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code.

~~Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code.~~

~~§ 1797.98h. Repealed by Stats.1994, c. 1143 (S.B.1683), § 2, operative Jan. 1, 2000~~

~~A new~~ Chapter 2.5 ~~of~~ Division 2.5 of the Health and Safety Code ~~is added~~ to read ~~as follows~~:

~~A General Provisions~~

~~Section 1797.98a of Chapter 2.5 of Division 2.5 of the Health and Safety Code is added to read:~~

§ 1797.98a. **(a)** There is hereby created the Emergency and Trauma Physician Services Commission in the Department of Health Services.

(b) The commission shall consist of ten members, appointed as follows:

(1) Three full-time physicians and surgeons who are board certified in emergency medicine and who are members of a professional medical association and are in a position to represent the interests of emergency physicians generally, appointed by the Governor of California; and

(2) Three full-time physicians and surgeons who provide on-call specialty services to hospital emergency departments and who are members of a professional medical association and are in a position to represent the interests of on-call physician specialists generally, appointed by the Governor of California; and

(3) One full-time physician and surgeon who is board certified in emergency medicine and who is a member of a professional medical association and is in a position to represent the interests of emergency physicians generally, appointed by the Senate Rules Committee; and

(4) One full-time physician and surgeon who provides on-call specialty services to hospital emergency departments and is a member of a professional medical association and is in a position to represent the interests of on-call physician specialists generally, appointed by the Senate Rules Committee; and

(5) One full-time physician and surgeon who is board certified in emergency medicine and who is a member of a professional medical association and is in a position to represent the interests of emergency physicians generally, appointed by the Speaker of the California State Assembly; and

(6) One full-time physician and surgeon who provides on-call specialty services to hospital emergency departments and who is a member of a professional medical association and is in a position to represent the interests of on-call physician specialists generally, appointed by the Speaker of the California State Assembly.

(c) The term of the members of the Commission shall be three calendar years, commencing January 1 of the year of appointment, provided that the initial terms of the members shall be staggered.

(d) The members of the Commission shall receive no compensation for their services to the Commission, but shall be reimbursed for their actual and necessary travel and other expenses incurred in the discharge of their duties.

(e) The Commission shall select a chairperson from its members, and shall meet at least quarterly on the call of the Director, the Chairperson, or two members of the Commission.

(f) The Commission shall advise the Director on all aspects of the Emergency and Trauma Physician Services Accounts, including both the Emergency and Trauma Physician Unpaid Claims Account and the Emergency and Trauma Physician Uninsured Account.

(g) A majority of both the emergency physician members and the on-call physician specialist members shall constitute a quorum, and no recommendation or action will be effective in the absence of a majority vote of emergency physician members and a majority vote of on-call physician specialist members.



(h) The Commission shall review and approve the forms, guidelines, and regulations implementing the Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts.

(i) The Commission shall review and approve applications by counties to administer their own Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts.

(j) For each calendar quarter and at the end of each calendar year, the Department of Health Services or, where applicable, the administering agency for each county shall report to the Legislature and the Emergency and Trauma Physician Services Commission on the implementation and status of the Maddy Emergency Medical Services Fund, Emergency and Trauma Physician Unpaid Claims Account and the Emergency and Trauma Physician Uninsured Account. These reports and the underlying data supporting these reports shall be publicly available. These reports shall, for the Department and each county, include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Maddy Emergency Medical Services Fund ("Fund").

(2) The total amount of funds allocated to each county administering the account from the Emergency and Trauma Physician Unpaid Claims Account ("Unpaid Claims Account").

(3) The total amount of funds allocated to each county administering the account from the Emergency and Trauma Physician Uninsured Account ("Uninsured Account").

(4) The Fund and Account balances and the amount of moneys disbursed from the Fund and Accounts to physicians.

(5) For both the Fund and Accounts, the pattern and distribution of claims, including but not limited to the total number of claims submitted by physicians and surgeons in aggregate from each facility.

(6) For both the Fund and the Accounts, the amount of moneys available to be disbursed to physicians, the dollar value of the total allowable claims submitted, and the percentage of such claims which were reimbursed.

(7) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(8) The actual administrative costs of the administering agency incurred in administering the program.

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(k)(1) The State Board of Equalization shall, on a quarterly basis, report to the Legislature and the Emergency and Trauma Physician Services Commission and make publicly available, amounts required to be paid to the 911 Emergency and Trauma Care Fund pursuant to section 41135 of the Revenue and Taxation Code and amounts credited to each of the accounts created within that fund.

(2) The administering agency, upon request, shall make available to any member of the public a listing of physicians and hospitals that have received reimbursement from the Unpaid Claims Account, the Uninsured Account and the Emergency and Trauma Hospital Services Account and the amount of the reimbursement they have received. This listing shall be compiled on a semi-annual basis.

(l) Each administering agency of an account under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in each county as to the availability of the accounts and the process by which to submit a claim against the accounts. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

(m) The Department may issue forms, guidelines or regulations to implement this chapter pursuant to Chapter 3.5 of Part I of Division 3 of the Government Code (commencing with Section 11340) ~~section 11340~~.

~~Section 1797.98b of Chapter 2.5 of Division 2.5 of the Health and Safety Code is added to read:~~

~~§~~1797.98b~~(a)~~ For purposes of this Chapter, the Department shall be the administering agency unless delegated to a county pursuant to subdivision (c).

(b) The Department shall be reimbursed from the state Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts for its actual costs of administration not to exceed 4% of the moneys credited to these accounts during the fiscal year, unless a different percentage is approved by the Emergency and Trauma Physician Services Commission as necessary for the efficient administration of the accounts.

(c) The Department may delegate to a county, upon application, the administration of its own County Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts. The Department shall establish terms and conditions for the delegation of a county to administer the accounts, which shall include, but not be limited to all of the following:

(1) The county Board of Supervisors shall request, by resolution, to be the administering agency and shall have established accounts within the Maddy Emergency Medical Services Fund;

(2) The resolution shall specify any delegation of this authority proposed by the county Board of Supervisors, and shall specify who will serve as the administering officer;

(3) The county is of sufficient size to justify such delegation as cost effective;

(4) The county has demonstrated its commitment to maintaining a stable and high quality emergency medical services system. An example of such commitment is a county's augmentation of funding for emergency medical services;

(5) The county will accept both paper and electronic claims;

(6) Administration by the county is supported by local physician organizations;

(7) The costs of administration will not exceed 4% of the money credited to these accounts during the fiscal year, or the amount authorized by the Emergency and Trauma Physician Services Commission as necessary for the efficient administration of the accounts;

(8) The Department may approve an application by a county for a period not more than three years. A county may thereafter reapply for delegation;

(9) The Department shall give great weight to the recommendations of the Emergency and Trauma Physician Services Commission during the application and review process and the Commission shall have final authority to approve applications pursuant to section 1797.98a(1)(i).

(d) If a county is delegated by the Department to be the administering agency, claims for emergency medical services provided at facilities within that county may only be submitted to that county, and may not be submitted to the Department.

(e) If a county is delegated by the Department to be the administering agency, the Department shall do all of the following:

(1) authorize a county to keep moneys deposited into that county's Emergency and Trauma Physician Unpaid Claims Account for reimbursements pursuant to this chapter,

(2) each calendar quarter, transfer to the County Emergency and Trauma Physician Services Unpaid Claims Account in that county funds deposited into the state Emergency and Trauma Physician Services Unpaid Claims Account pursuant to sections 16950 and 16950.2 of the Welfare and Institutions Code and allocated to that county by the Department based on the total population of that county to the total population of the state,

(3) each calendar quarter, transfer funds from the State Emergency and Trauma Physician Uninsured Account to that county's Emergency and Trauma Physician Uninsured Account, based on the total population of that county to the total population of the state, and

(4) authorize the county to deduct its actual costs of administration, not to exceed the amount authorized pursuant to subdivision (c)(7). paragraph (7) of

~~(f) Section 1797.98c of Chapter 2.5 of Division 2.5 of the Health & Safety Code is added to read:~~

§ 1797.98c (a) It is the intent of the People that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of claims submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency and Trauma Physicians Unpaid Claims Account and the Emergency and Trauma Physicians Uninsured Account on a quarterly basis to applicants who have submitted accurate and complete data for payment. The administering agency may, as necessary, request records and documentation to support the claims requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Claims submitted and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit claims that are inaccurate or unsupported by records may be excluded from submitting future claims. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the supervision of that person, shall not be the administering officer.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the Department may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out the provisions of this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

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(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the accounts to eligible physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the accounts shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A standby, basic, or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.



(g) Reimbursement for emergency services rendered under this chapter shall be limited to emergency services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days, however reimbursement for surgery for emergency services is permitted for up to seven calendar days if such surgery is necessary to stabilize the patient's emergency medical condition and could not be performed during the first three calendar days due to the patient's condition. Notwithstanding this subdivision, if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(h) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(i) The Department shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the accounts. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

~~Section 1797.98d of Chapter 2.5 of Division 2.5 of the Health & Safety Code is~~ added to read:

§ 1797.98d. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department, or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.99b are satisfied for reimbursement from the Unpaid Claims Account, and all provisions of Section 1797.98c are satisfied for reimbursement from the Uninsured Claims Account, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Uninsured and Unpaid Claims Accounts is sought by the hospital, or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

Article 2.

B. Emergency and Trauma Physician Unpaid Claims Account

Section 1797.99a of Chapter 2.5 of Division 2.5 of the Health and Safety Code is added to read:

1797.99a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) Each county shall establish a Maddy EMS Fund. Within the Maddy EMS Fund, each county shall establish a county Emergency and Trauma Physician Unpaid Claims Account and a county Emergency and Trauma Hospital Services Account. A county that has been designated as an administering agency pursuant to section 1797.98b(c), shall also establish a county Emergency and Trauma Physician Uninsured Account to receive funds transferred from the state Emergency and Trauma Physician Uninsured Account pursuant to sections 1797.98b(e)(3) and 1797.99c.

(c) The source of the money in each Maddy EMS Fund shall be the penalty assessments made for this purpose, as provided in Section 76000 of the Government Code, and allocated

pursuant to subdivision (d). Other money, which may be transferred from the state to accounts within the Maddy EMS Fund pursuant to this Chapter, is not subject to allocation pursuant to subdivision (d).

(d) ~~Fifty-eight~~ 58 percent (58%) of the money in the Maddy EMS Fund derived pursuant to subdivision (c) shall be deposited into the County Emergency and Trauma Physician Unpaid Claims Account. Each calendar quarter, the county Treasurer shall transfer the funds in the account to the state Treasurer for credit to the state Emergency and Trauma Physician Unpaid Claims Account created pursuant to Revenue and Taxation Code ~~section 41135(g)~~ subdivision (g) of section 41135 of the; ~~twenty-five~~ 25 percent (25%) shall be deposited into the County Emergency and Trauma Hospital Services Account for distribution by the county only to hospitals providing disproportionate trauma and emergency medical care services. The remaining money derived pursuant to subdivision (c) shall remain in each county and shall be used to reimburse the county for actual costs of administration and for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. All interest earned on moneys in each account within the Maddy EMS Fund shall be deposited in the same account for disbursement as specified in this Chapter.

(e) Funds in the state Emergency and Trauma Physician Unpaid Claims Account shall be continuously appropriated to and administered by the Department of Health Services. The Department shall transfer funds, as necessary, to a county that has been delegated the role of administering agency pursuant to ~~section 1797.98b(c)~~ subdivision (c) of Section 1797.98b. Such funds shall be continuously appropriated and allocated to and by the county pursuant to this Chapter. The administering agency shall allocate the funds solely for the reimbursement of physicians and surgeons providing uncompensated emergency services and care up to the time the patient is stabilized, except those physicians and surgeons employed by hospitals, pursuant to this Chapter. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(f) Any physician and surgeon may be reimbursed from the Emergency and Trauma Physician Unpaid Claims Account up to ~~fifty (50)~~ 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.99b for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to subdivision (d) of Section 1797.99b. All funds remaining at the end of the fiscal year, in excess of any reserve held and rolled-over to the next year pursuant to subdivision (g), shall be distributed proportionally based on the dollar amount of claims paid to all physicians and surgeons who submitted qualifying claims during that year.

(g) Each administering agency may hold in reserve and roll-over to the following year up to ~~fifteen (15)~~ 15 percent of the funds in the Emergency and Trauma Physician Unpaid Claims Account.

~~Section 1797.99b of Chapter 2.5 of Division 2.5 of the Health and Safety Code is added to read:~~

1797.99b. (a) Physicians and surgeons wishing to be reimbursed from the Emergency and Trauma Physician Unpaid Claims Account shall submit their claims for services provided to patients who





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do not make any payment for services and for whom no responsible third party makes any payment. If the services were provided in a county in which the county is the administering agency, the physician and surgeon shall submit the claim to that county and may not submit a claim to the Department. The administering agency shall accept both paper and electronic claims. Claims shall conform to the CMS 1500 forms, or in whatever format is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims. Payments from the Emergency and Trauma Physician Services Uninsured Account shall not constitute payment for services.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.



(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement for claims submitted by any physician and surgeon shall be limited to services provided to a patient who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of funds from the fund.

(5) The claim has been received by the administering agency within one year of the date of service.

(d) Notwithstanding any other restriction on reimbursement, the administering agency shall adopt a reimbursement methodology to establish a uniform reasonable level of reimbursement from the Unpaid Claims Account for reimbursable services using the Relative Value Units ("RVUs") established by the Resource Based Relative Value Scale ("RBRVS"). When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. The administering agency, upon approval by the Emergency and Trauma Physician Services Commission, may adopt a different reimbursement methodology to promote equitable compensation to the physician community as a whole for uncompensated emergency services and care. For the purpose of submission and reimbursement of claims, the administering agency shall adopt and use the current version of the Physician's Current Procedural Terminology, published by the American Medical Association, or whatever coding set is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims.

Article 3.

C. Emergency and Trauma Physician Uninsured Account — delete underscore and center

~~Section 1797.99c of Chapter 2.5 of Division 2.5 of the Health and Safety Code is added to read:~~

§ 1797.99c (a) Funds in the state Emergency and Trauma Physician Uninsured Account shall be continuously appropriated to and administered by the Department of Health Services. The Department shall transfer funds, as necessary, to a county that has been delegated the role of administering agency pursuant to section 1797.98b(c). Such funds shall be continuously appropriated and allocated to and by the county pursuant to this Chapter. The administering agency shall allocate the funds solely for the reimbursement of physicians and surgeons providing uncompensated emergency services and care up to the time the patient is stabilized, except those physicians and surgeons employed by hospitals, pursuant to this Chapter. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(b) Physicians and surgeons providing emergency services and care to an uninsured patient shall be entitled to receive reimbursement for services rendered to such patients, on a quarterly basis, from the account. For each such patient, a physician and surgeon shall bill the patient unless the physician and surgeon reasonably believes that the patient will not make payment. Physicians and surgeons shall submit a claim to the administering agency for reimbursement within one year of the day the services were rendered. If the services were provided in a county in which the county is the administering agency, the physician and surgeon shall submit the claim to that county and may not submit a claim to the Department. The administering agency shall accept both paper and electronic claims. Claims shall conform to the

CMS 1500 forms, or in whatever format is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims.

(c) For purposes of this chapter, the term "uninsured patient" means a patient that a physician and surgeon has determined after reasonable and prudent inquiry is without public or private third party health coverage. Payments by hospitals to physicians and surgeons to help assure the availability of physicians and surgeons to an emergency department or trauma center shall not be considered third party health coverage.

(d) The amount of reimbursement paid shall be based on the value of claims received by the administering agency during the calendar quarter for services rendered to uninsured patients, using the Relative Value Units ("RVUs") established by the Resource Based Relative Value Scale ("RBRVS") as the reimbursement methodology. For each calendar quarter, the administering agency will determine the total number of RVUs of services submitted, and shall pay each physician and surgeon submitting claims that physician's percentage of the total funds in the Account attributed to claims received for that calendar quarter, based on that physician's percentage of the total RVU pool. The administering agency, upon approval by the Emergency and Trauma Physician Services Commission, may adopt a different reimbursement methodology to promote equitable compensation to the physician community as a whole for uncompensated emergency services and care. For the purpose of submission and reimbursement of claims, the administering agency shall adopt and use the current version of the Physician's Current Procedural Terminology, published by the American Medical Association, or whatever coding set is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims. No physician shall be reimbursed in an amount greater than the total the physician has billed for the services claimed. The administering agency shall issue such reimbursements within ~~ninety (90)~~ days following the end of each calendar quarter. Undisbursed funds, if any, shall remain in the Account, and be rolled over to the following quarter.

(e) Within 30 days following the end of each calendar quarter, physicians and surgeons shall provide the administering agency with:

(1) a list of all claims for which reimbursement is received within one year of the date of service from any public or private third party health coverage and the amount which was received from the Uninsured Claims Account for each of these claims; and

(2) a list of all claims reimbursed by the Uninsured Claims Account for which the total reimbursement from all sources exceeds the physician's billed charges, and the amount of that excess reimbursement for each of these claims.

After such notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the Account by the amount the physician received for claims reported pursuant to ~~subdivision~~ (1), and by the amount of the excess payment for those claims reported pursuant to ~~subdivision~~ (2). In lieu of a reduction in future payments from the Account, the physician and surgeon shall refund excess payments to the Account with the lists referred to in ~~subdivisions~~ (1) and (2) described above. Physicians and surgeons who receive reimbursement

ital (CHAPTER 2.6. THE EMERGENCY AND TRAUMA HOSPITAL SERVICES ACCOUNT) Center CAPS + small CAPS

from the Uninsured Account shall agree to stop any current, and waive any future, collection efforts to obtain additional reimbursement from the patient should the total reimbursement from all sources reach or exceed the physician's or surgeon's billed charges.

SECTION 7. Administration of The Emergency and Trauma Hospital Services Account.

SEC. 7.1. Chapter 2.6 ~~of~~ Division 2.5 of the Health and Safety Code (commencing with section 1797.99h) ~~1797.99h) is added~~ is added to read:

§ 1797.99h. The following definitions shall apply to terms utilized in this chapter:

(a) "Bad debt cost" means the aggregate amount of accounts and notes receivable during a calendar year by an eligible hospital as credit losses, using any method generally accepted for estimating such amounts that on the date this Act became effective, based on a patient's unwillingness to pay, and multiplied by the eligible hospital's cost to charges ratio.

(b) "County indigent program effort cost" means the amount of care during a calendar year by an eligible hospital, expressed in dollars and based upon the hospital's full established rates, provided to indigent patients for whom the county is responsible, whether the hospital is a county hospital or a non-county hospital providing services to indigent patients under arrangements with a county, multiplied by the eligible hospital's cost to charges ratio.

(c) "Charity care cost" means amounts actually written off, using any method generally accepted for determining such amounts on the date this Act became effective, by an eligible hospital during a calendar year for that portion of care provided to a patient for whom a third party payer is not responsible and the patient is unable to pay, multiplied by the hospital's cost to charges ratio.

(d) "Cost to charges ratio" means a ratio determined by dividing an eligible hospital's operating expenses less other operating revenue by gross patient revenue for its most recent reporting period.

(e) "Operating expenses" means the total direct expenses incurred for providing patient care by the hospital. Direct expenses include (without limitation) salaries and wages, employee benefits, professional fees, supplies, purchased services, and other expenses.

(f) "Other operating revenue" means revenue generated by health care operations from non-patient care services to patients and others.

(g) "Gross patient revenue" means the total charges at the hospital's full established rates for the provision of patient care services and includes charges related to hospital-based physician professional services.

(h) "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are delivered.





SUBJECT TO COURT ORDERED CHANGES

(i) "Eligible hospital" means a hospital licensed under Section 1250 of the Health and Safety Code that operates an Emergency Department or a children's hospital as defined in Section 10727 of the Welfare & Institutions Code.

(j) "Emergency department encounter" or "emergency department visit" each means a face to face contact between a patient and the provider who has primary responsibility for assessing and treating the patient in an emergency department and exercises independent judgment in the care of the patient. An emergency department encounter or visit is counted for each patient of the emergency department, regardless of whether the patient is admitted as an inpatient or treated and released as an outpatient. An emergency department encounter or visit shall not be counted where a patient receives triage services only.

(k) "Emergency and disaster management plan" means a plan developed to provide appropriate response to emergencies and disasters, including preparedness activities, response activities, recovery activities, and mitigation activities.

(l) "Office" means the Office of Statewide Health Planning and Development.

(m) "Disaster" means a natural or man-made event that significantly: (A) disrupts the environment of care, such as damage to buildings and grounds due to severe wind storms, tornadoes, hurricanes, or earthquakes; (B) disrupts care and treatment due to: (i) loss of utilities including, but not limited to, power, water, and telephones, or (ii) floods, civil disturbances, accidents or emergencies in the surrounding community; or (C) changes or increases demand for the organization's services such as a terrorist attack, building collapse, or airplane crash in the organization's community.

(n) "Department" means the State Department of Health Services.

(o) "Funding percentage" means the sum of (1) an eligible hospital's percentage of hospital emergency care (as defined in subparagraph (s) below) multiplied by a factor of .80, added to (2) such hospital's percentage of effort (as defined in subparagraph (r) below) multiplied by a factor of .20, the sum to be expressed as a percentage.

(p) "Hospital Account" means the Emergency and Trauma Hospital Services Account of the 911 Fund established pursuant to subdivision (f) Section 41135 of the Revenue and Taxation Code.

(q) "911 Fund" means the 911 Emergency and Trauma Care Fund established pursuant to Section 41135 of the Revenue and Taxation Code.

(r) "Percentage of effort" means the sum of an eligible hospital's total amount of charity care cost plus that hospital's total amount of bad debt cost plus that hospital's county indigent program effort cost, as a percentage of the sum of the total amount of charity care cost plus the

total amount of bad debt cost plus the total county indigent program effort cost reported in final form to the Department by all eligible hospitals for the same calendar year.

(s) "Percentage of hospital emergency care" means an eligible hospital's total emergency department encounters for the most recent calendar year for which such data has been reported to the Department in final form, as a percentage of all emergency department encounters reported in final form by all eligible hospitals for the same calendar year. In the case of a children's hospital which does not operate an emergency department and provides emergency treatment to a patient under eighteen years of age under arrangements with an emergency department of a hospital that is: (1) located within ~~one thousand (1,000)~~ yards of the children's hospital, and (2) is either (a) under common ownership or control with the children's hospital or, (b) has contracted with the children's hospital to provide emergency services to its patients under ~~eighteen years of age, the~~ children's hospital providing emergency services to such patient shall receive credit for the emergency department encounter, and not the hospital operating the emergency department.

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(t) "Joint Commission on Accreditation of Healthcare Organizations" means that certain independent, nonprofit organization that evaluates and accredits nearly 18,000 health care organizations and programs in the United States, including hospitals, home care agencies, nursing facilities, ambulatory care facilities, clinical laboratories, behavioral health care organizations, HMOs, and PPOs.



(u) "American Osteopathic Association" means that certain nonprofit national association representing osteopathic physicians which accredits hospitals, and whose accreditation of hospitals is accepted for participation in the federal Medicare program.

§ 1797.99i. (a) The Department shall calculate each eligible hospital's funding percentage to be used for the next calendar year and notify each eligible hospital of its proposed funding percentage and that for all hospitals by no later than September 30 of each year.

(b) The Department shall receive and review the accuracy and completeness of information submitted by eligible hospitals pursuant to Section 1797.99j. The Department shall develop a standard form to be utilized for reporting such information by eligible hospitals, but shall accept information from eligible hospitals which is not reported on such standard form.

subdivision (a) of

(c) The Department shall notify each hospital submitting the information specified under section 1797.99j (a) in writing through a communication delivered by no later than April 30 of each year confirming the information it has from such hospital and of any apparent discrepancies in the accuracy, completeness, or legibility of information submitted by such eligible hospital pursuant to Section 1797.99j. Unless such written notice is timely delivered to an eligible hospital, the information it reports pursuant to Section 1797.99j shall be deemed to be complete and accurate, but it shall be subject to audit under subdivision (f).

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(d) A hospital which receives notice from the Department that the information it reported was not accurate, complete, or legible shall have ~~thirty (30)~~ days from the date notice is received to provide the Department with corrected, completed, and legible information. Such corrected or

supplemental information shall be used by the Department to make the calculation required by subdivision (a) of this section, but shall be subject to audit under subdivision (f). A hospital that does not provide sufficient legible information to establish that it qualifies as an eligible hospital or to allow the Commission to make the calculation required under subdivision (a) of this section shall be deemed to not be an eligible hospital.

(e) The Department may enter into an agreement with the Office of Statewide Health Planning and Development or another state agency or private party to assist it in analyzing information reported by eligible hospitals and making the hospital funding allocation computations as provided under this chapter.

(f) The Department may conduct audits of the use by eligible hospitals of any funds received pursuant to Section 1797.99l, and the accuracy of emergency department patient encounters and other information reported by eligible hospitals. If the Department determines upon audit that any funds received were improperly used, or that inaccurate data reported by the eligible hospital resulted in an allocation of excess funds to the eligible hospital, it shall recover any excess amounts allocated to, or any funds improperly used by, an eligible hospital. The Department may impose a fine of not more than ~~twenty-five percent (25%)~~ 25 of any funds received by the eligible hospital that were improperly used, or the Department may impose a fine of not more than two (2) times any amounts improperly used or received by an eligible hospital if it finds such amounts were the result of gross negligence or intentional misconduct in reporting data or improperly using allocated funds under this chapter on the part of the hospital subject to determination of a court of final jurisdiction. In no event shall a hospital be subject to multiple penalties for both improperly using and receiving the same funds.

(g)(1) A licensed hospital owner shall have the right to appeal the imposition of any fine by the Department, or a determination by the Department that its hospital is not an eligible hospital, for any reason, or an alleged computational or typographical error by the Department resulting in an incorrect allocation of funds to its hospital under Section 1797.99L A hospital shall not be entitled to be reclassified as an eligible hospital or to have an increase in funds received under this chapter based upon subsequent corrections to its own final reporting of incorrect data used to determine funding allocations under this chapter.

(2) Any such appeal shall be before an administrative law judge employed by the Office of Administrative Hearings. The hearing shall be held in accordance with Chapter 5 (commencing with section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The decision of the administrative law judge shall be in writing; shall include findings of fact and conclusions of law; and shall be final. The decision of the administrative law judge shall be made within 60 days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(3) The appeal rights of hospitals under this subdivision (g) shall not be interpreted to preclude any other legal or equitable relief that may be available.

(h) Any fines collected by the Department shall be deposited in the Hospital Account within the 911 Fund for allocation to eligible hospitals in accordance with the provisions of Section 1797.99l. Such funds shall not be used for administrative costs, and shall be supplemental to, and shall not supplant, any other funds available to be allocated from such account to eligible hospitals.

(i) In the event it is determined upon a final adjudicatory decision that is no longer subject to appeal that a hospital has been incorrectly determined to not qualify as an eligible hospital, or was allocated an amount less than the amount to which it is entitled under Section 1797.99l, the Department shall, from the next allocation of funds to hospitals under Section 1797.99l, allocate to such hospital the additional amount to which it is entitled, and reduce the allocation to all other eligible hospitals pro rata.

§ 1797.99j. (a) Each hospital seeking designation as an eligible hospital shall submit the following information to the Department by no later than March 15 of each year, commencing the first March 15 following the operative date of this Act:



(1) The number of emergency department encounters taking place in its emergency department for the preceding calendar year;

(2) The total amount of charity care costs of the hospital for the preceding calendar year;

(3) The total amount of bad debt costs for the hospital for the preceding calendar year;

(4) The total amount of county indigent program effort cost for the hospital for the prior calendar year;

(5) A photocopy of its operating license from the state Department of Health Services or equivalent documentation establishing that it operates a licensed emergency department;

(6) A declaration of commitment to provide emergency services as required by Section 1797.99k(a)(2). paragraph (2) of subdivision (a) of

(b) Both pediatric and adult patients shall be included in the data submitted. The accuracy of the data shall be attested to in writing by an authorized senior hospital official. No other data or information, other than identifying information, shall be required by the Department to be reported by eligible hospitals.

(c) Each hospital which receives a preponderance of its revenue from a single associated comprehensive group practice prepayment health care service plan shall report information required by this section for all patients, and not just for patients who are not enrolled in an associated health care service plan.

§ 1797.99k. An eligible hospital shall do all of the following throughout each calendar quarter in which it receives an allocation pursuant to Section 1797.99l:

(1) Maintain an operational emergency department available within its capabilities and licensure to provide emergency care and treatment, as required by law, to any pediatric or adult member of the public who has an emergency medical condition.

(2) On an annual basis, file with the Department a declaration stating the hospital's commitment to provide emergency services to victims of any terrorist act or any other disaster, within its capability, and to assist both the state and county in meeting the needs of their residents with emergency medical conditions.

(3) Either be accredited to operate an emergency department by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, or do all of the following:

(A) Participate in a minimum of two disaster training exercises annually.

(B) Provide training and information as appropriate to the hospital's medical staff, nurses, technicians, and administrative personnel regarding the identification, management, and reporting of emergency medical conditions and communicable diseases, as well as triage procedures in cases of mass casualties; and

(C) Collaborate with state and local emergency medical services agencies and public health authorities in establishing communications procedures in preparation for and during a disaster situation.

(4) Establish or maintain an emergency and disaster management plan. This plan shall include response preparations to care for victims of terrorist attacks and other disasters. The plan shall be made available by the hospital for public inspection.

(5) Each hospital shall annually prepare and issue a written report summarizing its compliance with this section.



§ 1797.99f. (a) Funds deposited in the Hospital Account, together with all interest and investment income earned thereon, shall be continuously appropriated without regard to fiscal years to and administered by the Department of Health Services. The Department shall allocate the funds solely to eligible hospitals as provided by this Chapter. State

(b) Quarterly, commencing June 30 following the operative date of this Chapter, the Department shall allocate to each eligible hospital a percentage of the balance of the Hospital Account equal to such hospital's funding percentage, as determined by the Department pursuant to section 1797.99i. Notwithstanding:

(1) The annual aggregate allocation to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan shall not exceed twenty-five million dollars ($25,000,000) during any calendar year, and the Department shall reduce the quarterly allocation to each such hospital pro rata, if and to the extent necessary, to contain the aggregate allocation to all such hospitals within any calendar year to a maximum of twenty-five million dollars ($25,000,000). The maximum annual aggregate allocation shall be applied by the Department in increments of six million two hundred and fifty thousand dollars ($6,250,000) to the first two quarterly distributions of each calendar year, but no specific portion of the limit on maximum annual aggregate distributions provided by this subsection shall apply to other quarterly distributions to such hospitals.

(2) The maximum aggregate annual allocation of twenty-five million dollars ($25,000,000) to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan set forth in

~~subdivision~~ (1) above shall be adjusted upward or downward annually, together with corresponding changes in any quarterly limits, commencing on January 1, 2006, by the same percentage increase or decrease in the aggregate amount deposited in the Hospital Account for the immediate prior calendar year against the aggregate amount deposited in the Hospital Account during the 2004 calendar year. Any adjustment that increases or decreases the maximum aggregate annual allocation to such hospitals shall be applied only to the then current calendar year.

(3) After making the adjustment to the maximum aggregate annual allocation to hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan provided by ~~subdivision (2)~~ above, the Department shall further adjust such maximum aggregate annual allocation by increasing or decreasing it by a percentage factor equal to the percentage increase or decrease in the aggregate funding percentage by all hospitals receiving a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan in 2004 against the aggregate funding percentage of all hospitals associated with the same health care service plan for the most recent calendar year.

(4) After making the adjustments to the allocation of funds as provided by ~~subdivisions~~ (1) through (3) above, the Department shall allocate any funds remaining in the Hospital Account to hospitals which do not receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan pro rata based upon their respective funding percentages.



(c) Prior to each allocation under subdivision (b), the actual costs of the Department (including any costs to the Department resulting from charges under section 11527 of the Government Code) for administering the provisions of this Chapter, and the percentage of costs incurred by the state Board of Equalization for its functions under Revenue and Taxation Code ~~Section 41135~~ equal to the percentage of remittances it receives under such section which are deposited in the Hospital Account, shall be reimbursed from the Hospital Account. The aggregate funds withdrawn for all administrative costs under this subdivision shall not exceed ~~one~~ percent (1%) of the total amounts deposited in the Hospital Account (not including any fines collected under section 1197.99(h)) during the prior quarter.

(d) An eligible hospital shall use the funds received under this section only to further the provision of hospital and medical services to emergency patients. A hospital may not utilize funds received under this chapter to compensate a physician and surgeon pursuant to a contractual agreement for medical services rendered to a patient that would cause total compensation to such physician and surgeon from all public and private sources, including the hospital, to exceed his or her billed charges.

§1797.99f. The Department may promulgate and adopt regulations to implement, interpret and make specific the provisions of this Chapter pursuant to the provisions of the Administrative Procedures Act set forth in Chapter 3.5 (commencing with Section 11342) of Part 1 of Division 3 of Title 2 of the Government Code. The Department shall have no authority to

promulgate quasi-legislative rules, or to adopt any rule, guideline, criterion, manual, order, standard, manual, policy, procedure or interpretation that is inconsistent with the provisions of this chapter. This section shall not be interpreted to allow the Department to adopt regulations (as defined by Government Code Section 11342.600) in contravention of Government Code ~~Section 11340.5~~.

SEC. 8.1.

Section 11342.600 of the

Section 11340.5 of the

SECTION 8. Preservation of Existing Funding

Section 16950 ~~of Article 3, Chapter 5, Part 4.7 of Division 9~~ of the Welfare and Institutions Code is amended to read:

90:51
5.37

§16950. (a) ~~T~~welve and two-tenths percent, or that portion of the CHIP Account derived from the Physician Services Account in a fiscal year, of each county's allocation under Section 16941 shall be used for the support of or payment for uncompensated physician services.

(b) Up to 50 percent of the moneys provided pursuant to subdivision (a) may be used by counties to pay for new contracts, with an effective date no earlier than July 1989, with private physicians for provision of emergency, obstetric, and pediatric services in facilities which are not owned or operated by a county, and where access to those services has been severely restricted. The contracts may provide for partial or full reimbursement for physician services provided to patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. ~~described in subdivision (f) of Section 16952, and shall be subject to subdivision (d) of Section 16955.~~

(c) ~~At least 50 percent of the moneys provided pursuant to subdivision (a) shall be transferred to the county Physician Services Account established in accordance with Section 16952 and administered in accordance with Article 3.5 (commencing with Section 16951).~~ Notwithstanding any other provision of this Code, at least 50 percent of the moneys provided pursuant to subdivision (a) shall be credited to the state Emergency and Trauma Physician Unpaid Claims Account established pursuant to Revenue and Taxation Code ~~section 41135(g)~~ and allocated for physician and surgeon reimbursement pursuant to Chapter 2.5 of Division 2.5 of the Health and Safety Code (commencing with section 1797.99a).

SEC. 8.2.

subdivision (g) of Section 41135 of the

Section 16950.2 ~~of Article 3, Chapter 5, Part 4.7 of Division 9 of the~~ Welfare and Institutions Code ~~is added~~ to read:

is added to the

§16950.2. (a) An amount, equal to the amount appropriated and allocated pursuant to Section 76 of Chapter 230 of the Statutes of 2003 (twenty-four million eight hundred three thousand dollars ($24,803,000)), shall be transferred and credited to the state Emergency and Trauma Physician Unpaid Claims Account, created pursuant to Revenue and Taxation Code ~~section 41135(g)~~, to be used only for reimbursement of uncompensated emergency services and care as provided in Chapter 2.5 of Division 2.5 (commencing with Section 1797.99a) of the

subdivision (g) of Section 41135 of the

established pursuant to

Health and Safety Code) from accounts within the Cigarette and Tobacco Products Surtax Fund (commencing with Section 30122 of the Revenue and Taxation Code) as follows:

(1) Nine million fifteen thousand dollars ($9,015,000) from the Hospital Services Account within the Cigarette and Tobacco Products Surtax Fund;

(2) Two million three hundred twenty-eight thousand dollars ($2,328,000) from the Physician Services Account within the Cigarette and Tobacco Products Surtax Fund;

(3) Thirteen million four hundred sixty thousand dollars ($13,460,000) from the Unallocated Account within the Cigarette and Tobacco Products Surtax Fund

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(b) This transfer shall be made on June 30 of the first fiscal year following adoption of this Act, and on June 30 each fiscal year thereafter.

SEC. 8.3.

(c) Nothing in this section shall preclude the Legislature from making additional appropriations from any source for the benefit of the Emergency and Trauma Physician Unpaid Account.

Section 16950.3 of Article 3, Chapter 5, Part 4.7 of Division 9 of the Welfare and Institutions Code ~~is added~~ is added to to read:



State

§16950.3. (a) An amount, equal to the amount allocated by the Department of Health Services pursuant to Item 4260-111-0001 (16) of Chapter 157 of the Statutes of 2003 (six million seven hundred fifty six thousand dollars ($6,756,000), shall be transferred and credited to the state account, created pursuant to Revenue and Taxation Code section 41135(d), to be used only for reimbursement of community clinic uncompensated primary care as provided in Chapter 7 of Part 4 of Division 106 of the Health and Safety Code (commencing with Section 124900) from the unallocated account within the Cigarette and Tobacco Products Surtax Fund (commencing with Section 30122 of the Revenue and Taxation Code).

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established pursuant to section 30122 of the Revenue and Taxation Code

(b) This transfer shall be made on June 30 of the first fiscal year following adoption of this Act, and on June 30 each fiscal year thereafter.

(c) Nothing in this section shall preclude the Legislature from making additional appropriations from any source for the benefit of the state account, created pursuant to Revenue and Taxation Code ~~section 41135(d)~~ subdivision (d) of section 41135 of the.

Sections 16951, 16952, 16953, 16953.1, 16953.2, 16953.3, 16955, 16955.1, 16956, 16957, 16958, 16959 of Article 3.5 of Division 9 of the Welfare and Institutions Code are repealed

~~§16951. As a condition of receiving funds pursuant to this chapter, each county shall establish an emergency medical services fund as authorized by subdivision (a) of Section 1797.98 of the Health and Safety Code. This section shall not be interpreted to require any county to impose the assessment authorized by Section 1465 of the Penal Code.~~

1:1331
5.9



subdivision (d) of Section 41135 of the



SEC. 8.4. Section 16951 of the Welfare and Institutions Code is repealed.

Section 16952 of the Welfare and Institutions Code is repealed.

~~§16952(a)(1) Each county shall establish within its emergency medical services fund a Physician Services Account. Each county shall deposit in the Physician Services Account those funds appropriated by the Legislature for the purposes of the Physician Services Account of the fund.~~ 94:195 S.45

~~(2)(A) Each county may encumber sufficient funds to reimburse physician losses incurred during the fiscal year for which bills will not be received until after the fiscal year.~~

~~(B) Each county shall provide a reasonable basis for its estimate of the necessary amount encumbered.~~

~~(C) All funds which are encumbered for a fiscal year shall be expended or disencumbered prior to the submission of the report of actual expenditures required by Sections 16938 and 16980.~~

~~(b) Funds deposited in the Physician Services Account in the county emergency medical services fund shall be exempt from the percentage allocations set forth in subdivision (a) of Section 1797.98. However, funds in the county Physician Services Account shall not be used to reimburse for physician services provided by physicians employed by county hospitals.~~



~~No physician who provides physician services in a primary care clinic which receives funds from this act shall be eligible for reimbursement from the Physician Services Account for any losses incurred in the provision of those services.~~



~~(c) The county physician services account shall be administered by each county, except that a county electing to have the state administer its medically indigent adult program as authorized by Section 16809, may also elect to have its county physician services account administered by the state in accordance with Section 16954.~~

~~(d) Costs of administering the account shall be reimbursed by the account, up to 10 percent of the amount of the account.~~

~~(e) For purposes of this article "administering agency" means the agency designated by the board of supervisors to administer this article, or the department, in the case of those CMSP counties electing to have the state administer this article on their behalf.~~

~~(f) The county Physician Services Account shall be used to reimburse physicians for losses incurred for services provided during the fiscal year of allocation due to patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.~~

~~(g)(1) Reimbursement for losses shall be limited to emergency services as defined in Section 16953, obstetric, and pediatric services as defined in Sections 16905.5 and 16907.5, respectively.~~

~~(2) It is the intent of this subdivision to allow reimbursement for all of the following:~~

SEC. 8.6.

~~(A) All inpatient and outpatient obstetric services which are medically necessary, as determined by the attending physician.~~

~~(B) All inpatient and outpatient pediatric services which are medically necessary, as determined by the attending physician.~~

~~(h) No physician shall be reimbursed for more than 50 percent of the losses submitted to the administering agency.~~

Section 16953 of the Welfare and Institutions Code is repealed.

~~§ 16953.(a) For purposes of this chapter "emergency services" means physician services in one of the following:~~

96:1023
S.494

~~(1) A general acute care hospital which provides basic or comprehensive emergency services for emergency medical conditions.~~

~~(2) A site which was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients, for emergency medical conditions.~~

~~(3) Beginning in the 1991-92 fiscal year and each fiscal year thereafter, in a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services, for emergency medical conditions.~~

~~(4) A standby emergency room in a hospital specified in Section 124840 of the Health and Safety Code, for emergency medical conditions.~~

~~(b) For purposes of this chapter, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:~~

~~(1) Placing the patient's health in serious jeopardy.~~

~~(2) Serious impairment to bodily functions.~~

~~(3) Serious dysfunction to any bodily organ or part.~~

~~(c) It is the intent of this section to allow reimbursement for all inpatient and outpatient services which are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider.~~

Section 16953.1 of the Welfare and Institutions Code is repealed,

~~§ 16953.1. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the physician services account in the county's emergency medical services fund for services provided in that hospital, if all of the following conditions are met:~~

91:278
S.20

SEC. 8.7.

~~(a) The services are provided in a basic or comprehensive general acute care hospital emergency department.~~

~~(b) The physician and surgeon is not an employee of the hospital.~~

~~(c) All provisions of Section 16955 are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.~~

~~(d) Reimbursement from the physician services account in the county's emergency medical services fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.~~

SEC. 8.9.

~~(e) For purposes of this section, "gross billings arrangement" means an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or an emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.~~

Section 16953.2 of the Welfare and Institutions Code is repealed.

~~§ 16953.2. Nothing in this article shall prevent a physician from utilizing an agent who furnishes billing and collection services to the physician to submit claims or receive payment for claims.~~ (91: 278 S. 21)

Section 16953.3 of the Welfare and Institutions Code is repealed.

~~§ 16953.3. Notwithstanding any other restrictions on reimbursement, a county may adopt a fee schedule to establish a uniform, reasonable level of reimbursement from the physician services account for reimbursable services.~~ (91: 278 S. 22)

SEC. 8.10.

Section 16955 of the Welfare and Institutions Code is repealed.

~~§ 16955. Reimbursement for losses incurred by any physician shall be limited to services provided to a patient defined in subdivision (f) of Section 16952, and where all of the following conditions have been met:~~ (90: 51 S. 41)

~~(a) The physician has inquired if there is a responsible third party source of payment.~~

~~(b) The physician has billed for payment of services.~~

~~(c) Either of the following:~~

~~(1) A period of not less than three months has passed from the date the physician billed the patient or responsible third party, during which time the physician has made reasonable efforts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.~~

~~(2) The physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician.~~

SEC. 8.11.

~~(d) The physician has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of funds from the county physician services account in the county emergency medical services fund.~~

Section 16955.1 of the Welfare and Institutions Code is repealed.

~~§16955.1. This article shall not be applied or interpreted so as to prevent a physician from seeking payment from a patient or responsible third party payor, or arranging a repayment schedule for the costs of services rendered prior to receiving payment under this article.~~ (90:51 S.42)

SEC. 8.12.

Section 16956 of the Welfare and Institutions Code is repealed.

~~§16956. (a) The administering agency shall establish procedures and time schedules for submission and processing of reimbursement claims submitted by physicians in accordance with this chapter.~~ (90:50 S.24)

~~(b) Schedules for payment established in accordance with this section shall provide for disbursement of the funds available in the account periodically and at least annually to all physicians who have submitted claims containing accurate and complete data for payment by the dates established by the administering agency.~~

~~(c) Claims which are not supported by records may be denied by the administering agency, and any reimbursement paid in accordance with this chapter to any physician which is not supported by records shall be repaid to the administering agency, and shall be a claim against the physician.~~

~~(d) Any physician who submits any claim for reimbursement under this chapter which is inaccurate or which is not supported by records may be excluded from reimbursement of future claims under this chapter.~~

SEC. 8.13.

~~(e) A listing of patient names shall accompany a physician's claim, and those names shall be given full confidentiality protections by the administering agency.~~

SEC. 8.14.

Section 16957 of the Welfare and Institutions Code is repealed.

~~§16957. Any physician who submits any claim in accordance with this chapter shall keep and maintain records of the services rendered, the person to whom services were rendered, and any additional information the administering agency may require, for a period of three years after the services were provided.~~ (89:1331 S.9)

Section 16958 of the Welfare and Institutions Code is repealed.

~~§16958. If, after receiving payment from the account, a physician is reimbursed by a patient or a responsible third party, the physician shall do one of the following:~~ (90:51 S.43)

~~(a) Notify the administering agency and the administering agency shall reduce the physician's future payment of claims from the account. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician shall reimburse the account in an amount equal to the amount collected from the patient or third party payer, but not more than the amount of reimbursement received from the account.~~

SEC. 8.15.

~~(b) Notify the administering agency of the payment and reimburse the account in an amount equal to the amount collected from the patient or third party payor, but not more than the amount of the reimbursement received from the account for that patient's care.~~

Section 16959 of the Welfare and Institutions Code is repealed. 91:1169 S.5

~~§ 16959. The moneys contained in a Physician Services Account within an Emergency Medical Services Fund shall not be subject to Chapter 2.5 (commencing with Section 1797.98a) of Division 2.5 of the Health and Safety Code.~~

SECTION 9. New Funds Not to Supplant Existing Funds

Funds allocated and appropriated pursuant to this Act shall be used to supplement existing levels of federal, state and local funding and not to supplant existing levels of funding.

SECTION 10. Amendment

This Act may only be amended by the Legislature to further its purposes by a statute passed in each house by roll-call vote entered in the journal, four-fifths of the membership concurring.



SECTION 11. Operative Date

This Act shall become effective immediately upon its adoption by the people, however it shall not become operative until January 1 in the year following its adoption.

SECTION 12. Severability

If any provision of this Act, or part thereof, is for any reason held to be invalid or unconstitutional, the remaining provisions shall not be affected, but shall remain in full force and effect, and to this end the provisions of this Act are severable. In addition, the provisions of this Act are intended to be in addition to and not in conflict with any other initiative measure that may be adopted by the people at the same election, and the provisions of this Act shall be interpreted and construed so as to avoid conflicts with any such measure whenever possible. In the event the distribution of funds from any of the accounts established by subdivisions (c), (d), (e), (f), or (g) of Section 41135 of the Revenue and Taxation Code is permanently enjoined or invalidated by final judicial action that is not subject to appeal, the funds in any such account shall be continuously transferred to all other accounts in the 911 Emergency and Trauma Care Fund on the same basis as funds are allocated to such accounts by Section 41135 of the Revenue and Taxation Code. Funds remaining in the account shall be allocated as many times as necessary to reduce the account balance to ten thousand dollars ($10,000) or less.

SECTION 13. Conformity with State Constitution

SEC. 13.1. Section 14 is added to Article XIIIB of the California Constitution to read:

SEC.

~~SEC~~. 14. "Appropriations subject to limitation" of each entity of government shall not include appropriations of revenue from the 911 Emergency and Trauma Care Fund created by the 911 Emergency and Trauma Care Act. No adjustment in the appropriations limit of any entity of government shall be required pursuant to Section 3 as a result of revenue being deposited in or appropriated from the 911 Emergency and Trauma Care Fund. The surcharge created by the 911 Emergency and Trauma Care Act shall not be considered General Fund revenues for the purposes of Section 8 and 8.5 of Article XVI.

8



SUBJECT TO COURT ORDERED CHANGES